STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

LINDA A. WATTERS, COMMISSIONER,
OFFICE OF FINANCIAL AND INSURANCE SERVICES
FOR THE STATE OF MICHIGAN,

Petitioner,

File No. 03-1127-CR

v.

THE WELLNESS PLAN,
A Michigan health maintenance organization

Hon. William E. Collette

Respondent.
_____/

BRIEF ON THE ISSUE OF PRIORITY OF PROVIDER CLAIMS SUBMITTED BY HARRY L. SIVLEY, SPECIAL DEPUTY RECEIVER OF COMPREHENSIVE HEALTH SERVICES OF TEXAS, d/b/a WELLCHOICE

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Assets,
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INTRODUCTION

Harry L. Sivley, Special Deputy Receiver under contract with Jose Montemeyor, the Texas Commissioner of Insurance, submits this brief to address the issue of whether pre-rehabilitation provider claims have a priority in payment in The Wellness Plan rehabilitation.

In summary, the answer is no, they do not. The simplest and most obvious reason is that The Wellness Plan is solvent by a substantial margin eliminating any issue of priority among creditors inter se. Beyond that, HMOs are not insurance companies and do not issue insurance policies. Provider claims are not claims under policies of insurance. They are merely contract claims with the same priority as the other vendors.

BACKGROUND

WellChoice as a Creditor

Comprehensive Health Services of Texas d/b/a WellChoice, (herein "WellChoice"), is a Texas HMO that is a wholly owned subsidiary of The Wellness Plan. WellChoice failed in 1999 and was put into receivership by the Texas Commissioner of Insurance. The WellChoice receiver has filed a claim against The Wellness Plan, the face amount of which exceeds $6 million. As of yet, the claim has been neither allowed nor challenged. The resolution of this claim is the sole remaining matter to be resolved before the WellChoice creditors can be paid and the Texas receivership closed.

The inbound claims against the Texas HMO result primarily from its operations in one year, 1998. The significance of this fact is that WellChoice would have been put out of business a year earlier but for the written commitment made by The Wellness Plan to WellChoice, its auditors, and the Texas Department of Insurance in early 1998. That written commitment stated that The Wellness Plan would "...provide cash flow to Comprehensive Health Services of Texas d/b/a/ WellChoice in 1998, should the need arise." Exhibit A. This commitment was hand delivered to the Texas Department of Insurance in Austin, Texas shortly after it was penned.

Relying on this written commitment, the Texas Department of Insurance allowed the Texas HMO to stay in business one more year. When it was put into receivership the next year, its receiver asked The Wellness Plan to provide the funding it promised. It refused to do so. Suit was filed to collect the amount owing by The Wellness Plan in the Texas receivership court. After more than a year of litigation in Texas, The Wellness Plan itself was put into receivership in Michigan by the Michigan Insurance Bureau. Its estate is now being administered in this court.

The Priority Issues

The issue for which this brief is submitted has been framed as one seeking a determination of whether the claims of pre-rehabilitation medical providers have a priority over other claims in this rehabilitation. There are three groups of creditors potentially impacted by this issue, medical providers, direct medical malpractice claimants and "others".

Because The Wellness Plan is a solvent HMO in rehabilitation the law is that all of these creditors share on an equal basis. There is no priority issue.

ARGUMENT

I. The Wellness Plan is Solvent Eliminating the Need for a Determination of The Relative Priorities, IF ANY, of Its Creditors

Attached as Exhibit B are copies of the *Balance Sheet* and *Notes to Financial Statement* portions of the December 31, 2004 Annual Report prepared and filed by the rehabilitator in the past few weeks. This form is a required filing for HMOs around the country. There is a similar form filed each year by property and casualty insurance companies and another similar form filed by life and health insurance companies. In essence each is a comprehensive financial statement following statutory accounting principles.

Wellness Plan's balance sheet shows "cash and invested assets" with a value of $74,718,388 (Exhibit B, p 2, *Assets,* line 10), and net admitted assets with a reported value of $78,671,368. (Exhibit B, p 2, *Assets*, lines 24 & 26). Against this, the total liabilities are reported at $40,347,798. (Exhibit B, p 3, *Liabilities, Capital and Surplus,* line 22). Thus, after accounting for all outstanding obligations, The Wellness Plan has a net surplus of $38,323,570--an amount sufficient to pay the face amount of its reported liabilities by a factor of 170%. (Exhibit B, p 3, *Liabilities, Capital and Surplus,* Line 30).

For reasons that are unclear, the Annual Statement does not include the WellChoice claim in the listing of liabilities, although the *Notes to Financial Statement* identify the WellChoice claim noting that "Management believes that any obligation the Corporation may incur on behalf of WellChoice would not have a material adverse effect on the consolidated financial position of the Corporation." (Exhibit B, p 25.3, *Notes,* paragraph 14).

The only time that it is necessary for a receiver to seek a determination of the relative priorities of various creditors is when there is not enough money to go around. The Wellness Plan has more than enough money to go around by a multiple and will be able to emerge from rehabilitation as a well funded going-forward business.

While Commissioner Watters is to be commended on the successful rehabilitation of The Wellness Plan, the priority ruling being sought is not ripe for determination and in all likelihood never will be.

II. An HMO is Not Insurance Company and Does Not Issue Insurance Policies

The Wellness Plan receiver has identified the bulk of the claims filed against The Wellness Plan in the attachment to *Rehabilitator's Petition to Approve Claims Adjudication Procedures for Pre-Rehabilitation Medical Provider and Vendor Claims* dated November 30, 2004 and approved by this Court's Order of December 2, 2004. In that Petition the claims are divided into two categories, medical providers and vendors. While there may be other priority issues imbedded in the facts of this rehabilitation if The Wellness Plan was insolvent, the primary priority issue presently framed is whether the claims of Pre-Rehabilitation Medical Providers are to be treated as Class 2 claims under

policies under MCL 500.8142, *Priority of distribution of claims from insurer's estate; class of claims; subclasses prohibited; order of distribution; assets in separate account; definitions*, subsection (b), subordinated only to administrative expenses and certain employee claims. If the medical provider claims are not claims under policies, they fall into the general creditor class, Class 5.

In Michigan, HMOs are not insurance companies and do not issue insurance policies. The provider claims are merely contract claims.

Admittedly HMOs are regulated by the Michigan Office of Financial and Insurance Services ("OFIS") and were previously regulated by the Michigan Insurance Bureau. OFIS regulates a number of types of financial entities, many of which are engaged in the business of insurance in one way or another. But, not all are insurance companies.

In *Michigan Podiatric Medical Association v. National Foot Care Program, Inc.* 175 Mich App 723; 438 NW 2d 349 (1989), a podiatric association and individual podiatrists had brought an action against an alternative health maintenance organization which had contracted with a corporation to provide podiatric services for that corporation's employees in exchange for a preset fee paid by the corporation. Plaintiffs alleged that as result of a change of provision of health care services at the corporation, plaintiffs lost patients and income and suffered damage to their reputation.

In part plaintiffs asserted that the defendant had operated in violation of *MCL 550.51 et seq,. Prudent Purchaser Act (PPA); MCL 550.1101 et seq., The Nonprofit Health Care Corporation Reform Act, and MCL 500.100, et seq., The Insurance Code.*

In addressing to plaintiffs' contentions, the Michigan Court of Appeals succinctly summarized the difference between an insurance company and its products and those of an HMO:

> Section 106 of the Insurance Code, MCL 500.106; M.S.A. 24.1106, defines an "insurer" as "any ... corporation ... engaged or attempting to engage in the business of making insurance contracts or surety contracts." While defendant's health care contracts do provide that defendant will partially reimburse a subscriber for the cost of treatment obtained from a non-designated podiatrist, we agree with the trial court that this provision does not transform defendant into an "insurer."

> To a certain extent, HMOs do have a unique character. Rather than providing health insurance and paying for the bills after the insured has been treated by a doctor, an HMO is a prepaid plan where the participant pays before hand for the services themselves. See Chafetz, *The Federally Qualified Health Maintenance Organization: An Analysis of Federal Legislation Agency Action*, 16 New Eng L Rev 689 (1981). Under traditional definitions, a health maintenance organization does not sell insurance. *New Mexico Life Ins. Guaranty Ass'n v Moore*, 93 NM 47; 596 P2d 260 (1979)." [*United States Fidelity & Guaranty Co, supra* 131 Mich App, p 272.]

As explained in *Moore*, supra 93 N.M., p. 50, [596 P.2d 20], quoting *Jordan v. Group Health Ass'n,* 71 US App DC 38, 46; 107 F.2d 239 (1939):

> "Although Group Health's activities may be considered in one aspect as creating security against loss from illness or accident, more truly they constitute the quantity purchase of well-rounded, continuous medical service by its members. Group Health is in fact and in function a consumer cooperative. The functions of such an organization are not identical with those of insurance or indemnity companies. The latter are concerned primarily, if not exclusively, with risk.... On the other hand, the cooperative is concerned primarily with getting service rendered to its members."

The primary service offered by defendant is the provision of podiatric services to subscribers in consideration of prepayment for such services. Defendant is not an insurer as defined in the Insurance Code." 175 Mich. App. 723, 732.

Michigan Podiatric Medical Ass'n, 175 Mich App at 732-733,

In 1985 the question of whether a Michigan HMO was an insurance company was before the United States Bankruptcy Court for the Eastern District of Michigan in *In re Michigan Master Health Plan, Inc.* 90 BR 274 (ED Mich 1985). Because insurance companies are not eligible to be debtors under the federal bankruptcy code, 11 USC 109(b)(2), the issue was whether Master Health Plan, a Michigan HMO, was properly before the court as a debtor. The court held that the HMO was not an insurance company and was eligible to be a debtor under the bankruptcy code.

The current Michigan statutory framework for HMOs is set out in Chapter 35 of the Michigan Insurance Code, MCL 500.3501 *et seq*. Section 3501(f), MCL 500.3501(f), provides the following definition:

(f) "Health maintenance organization" means an entity that does the following:

> (i) Delivers health maintenance services that are medically indicated to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.
>
> (ii) Is responsible for the availability, accessibility, and quality of the health maintenance services provided.

This definition is identical to that which was before the *Michigan Master Health Plan* court. In reaching its decision the court concluded:

> A health maintenance organization is clearly not an insurance company. It is not created in the same manner as an insurance company and can take any form--profit, non-profit, partnership, sole proprietorship, etc.--and is, if a corporation, incorporated under the Business Corporation Act.
>
> *Michigan Master Health Plan,* 90 BR at 277.

In fact, Michigan's current statutory scheme for HMOs makes it clear that they are not insurance companies although *some* of the statutory insurance provisions do apply to them while others do not. In this regard, MCL 500.3503 provides:

> (1) All of the provisions of this act[1] that apply to a domestic insurer authorized to issue an expense-incurred hospital, medical, or surgical policy or certificate, including, but not limited to, section 223[2] and chapters 34[3] and 36[4], apply to a health maintenance organization under this chapter unless specifically excluded, or otherwise specifically provided for in this chapter.
>
> (2) Sections 408[5], 410[6], 411[7], 901[8], and 5208[9] and chapters 77[10] and 79[11] do not apply to a health maintenance organization.

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[1] The Insurance Code of 1956.
[2] MCL 500.223. Application for original or reissued certificate of authority by insurer; fee, deposit
[3] MCL 500.3400, et seq., Chapter 34. Disability Insurance Policies
[4] MCL 500.3600, et seq., Chapter 36. Group and Blanket Disability Insurance
[5] MCL 500.408. Capital, surplus or assets; minimum
[6] MCL 500.410. Capital and surplus; minimum, additional surplus; compliance with additional standards
[7] MCL 500.411. Authority to transact insurance; domestic, foreign, and alien insurers, deposits
[8] MCL 500.901. Minimum assets; liabilities and reserves
[9] MCL 500.5208. Corporate powers; limitation; exception; services in connection with noninsured benefit plan; standards

Additionally, a Michigan health maintenance organization is prohibited from using "...in its name, contracts, or literature the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of an insurance or surety corporation doing business in this state." MCL 500.3505.

Finally, one might anticipate an "equitable" argument from the medical providers that somehow they stand in the shoes of the enrollees who are the beneficiaries under the certificates of coverage issued by the HMO and are thus subrogated to the population of individuals who normally have claims under policies. As a matter of law, unlike insureds whose insurance company has gone broke, enrollees under an HMO plan do not bear the risk of loss for pre-receivership medical expenses that they have incurred. There simply is no population of persons and entities whose positions parallel those of policyholders with insurance policies.

It is of the essence of the structure of an HMO system that, with exception for non-contract, out-of-network claims, the risk of loss is born by the providers who have contracted with the HMO. They have all negotiated contracts with the HMO to provide services in exchange for prepayment. That is part of their business.

To emphasize the legal fact of life that providers who contract with HMOs must retain the risk of loss in the event the HMO fails to pay them, Michigan statutes, like those of other states, mandate that the provider contracts with the HMO "...shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect co-payments and deductibles directly from enrollees." MCL 500.3529.

CONCLUSION

Although, as a general proposition of law, receivers may seek guidance on legal issues from the receivership court, it is respectfully suggested that the advisory opinion being sought in this case is unnecessary. As to the merits of the issue, the Michigan

[10] MCL 500.7700, et seq., Chapter 77. Michigan Life and Health Insurance Guaranty Association Act
[11] MCL 500.7900, et seq., Chapter 79. Michigan Property and Casualty Guaranty Association Act

legislature has opted not to provide medical providers with any special priority over other creditors. Any claims that they have arise from a business risk they voluntarily contracted to undertake. Nothing more.

Dated this 20th day of April 2005.

Harry L. Sivley, Special Deputy Receiver Of Comprehensive Health Services of Texas, Inc., d/b/a/ WellChoice

By: _____

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EXHIBIT

A

PBL

THE WELLNESS PLAN

Comprehensive Health Services, Inc. • 2875 West Grand Boulevard • Detroit, Michigan 48202 • (313) 875-3700

March 3, 1998

John Lucas, Partner
BDO Seidman
Accountants and Consultants
755 West Big Beaver
Suite 1900
Troy, MI 48084-0178

Dear John,

This is to advise you that The Wellness Plan intends to provide cash flow to Comprehensive Health Services of Texas d/b/a WellChoice in 1998, should the need arise. If I may be of further service, please advise.

Very truly yours,

L. T. Mathews

Lawrence T. Mathews, Ph.D., CPA
Vice President & CFO

/lll
cc: J.W. Patton
I.J. King
N.S. Rangarajan

NOTE: This assurance from The Wellness Plan mitigates any going concern issue. Per discussion with John Lucas, BDO-Seidman, TWP has adequate resources to fund WellChoice through the end of 1998.

A Federally Qualified State Licensed Health Maintenance Organization

X-7

EXHIBIT B

HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDING DECEMBER 31, 2004

OF THE CONDITION AND AFFAIRS OF THE

THE WELLNESS PLAN

NAIC Group Code 1150 (Current Period) 1150 (Prior Period) NAIC Company Code 95471 Employer's ID Number 38-2008890

Organized under the Laws of Michigan State of Domicile or Port of Entry Michigan

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health [ ] Property/Casualty [ ] Dental Service Corporation [ ]
Vision Service Corporation [ ] Other [ ] Health Maintenance Organization [X]
Hospital, Medical & Dental Service or Indemnity [ ] Is HMO, Federally Qualified? Yes [X] No [ ]

Incorporated 11/08/1972 Commenced Business 02/28/1973

Statutory Home Office 7700 SECOND AVENUE (Street and Number), DETROIT, MI 48202 (City or Town, State and Zip Code)

Main Administrative Office 7700 SECOND AVENUE (Street and Number)
DETROIT, MI 48202 (City or Town, State and Zip Code) 313-202-8500 (Area Code) (Telephone Number)

Mail Address 7700 SECOND AVENUE (Street and Number or P.O. Box), DETROIT, MI 48202 (City or Town, State and Zip Code)

Primary Location of Books and Records 7700 SECOND AVENUE (Street and Number)
DETROIT, MI 48202 (City or Town, State and Zip Code) 313-202-8500-27828 (Area Code) (Telephone Number)

Internet Website Address www.wellplan.com

Statutory Statement Contact Rao Kakarala Mr. (Name) 313-202-8500-27828 (Area Code) (Telephone Number) (Extension)
rkakarala@wellplan.com (E-mail Address) 313-202-6870 (FAX Number)

Policyowner Relations Contact 7700 SECOND AVENUE (Street and Number)
DETROIT, MI 48202 (City or Town, State and Zip Code) 313-202-8500 (Area Code) (Telephone Number) (Extension)

OFFICERS

Name	Title	Name	Title
James Eric Gerber	Deputy Rehabilitator		

OTHER OFFICERS

DIRECTORS OR TRUSTEES

State of Michigan
County of Wayne ss

The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

James Eric Gerber
Deputy Rehabilitator

Subscribed and sworn to before me this
24 day of February, 2005

Polly J. Jones
Notary Public, Wayne County, MI
August 17, 2007

a. Is this an original filing? Yes [X] No [ ]
b. If no,
1. State the amendment number
2. Date filed
3. Number of pages attached

ASSETS

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D)	644,613		644,613	0
2. Stocks (Schedule D):				
2.1 Preferred stocks	0		0	0
2.2 Common stocks	0		0	11,481,304
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ ____ encumbrances)	18,829,675		18,829,675	20,275,152
4.2 Properties held for the production of income (less $ ____ encumbrances)			0	0
4.3 Properties held for sale (less $ ____ encumbrances)			0	0
5. Cash ($ 51,760,048 , Schedule E, Part 1), cash equivalents ($ 3,154,295 , Schedule E, Part 2) and short-term investments ($ 0 , Schedule DA)	54,914,343		54,914,343	33,348,869
6. Contract loans, (including $ ____ premium notes)			0	0
7. Other invested assets (Schedule BA)	329,757	0	329,757	1,060,195
8. Receivable for securities			0	0
9. Aggregate write-ins for invested assets	0	0	0	0
10. Subtotals, cash and invested assets (Lines 1 to 9)	74,718,388	0	74,718,388	66,165,510
11. Investment income due and accrued	32,246		32,246	46,295
12. Premiums and considerations:				
12.1 Uncollected premiums and agents' balances in the course of collection	154	154	0	655,510
12.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ____ earned but unbilled premium)			0	0
12.3 Accrued retrospective premium			0	0
13. Reinsurance:				
13.1 Amounts recoverable from reinsurers			0	0
13.2 Funds held by or deposited with reinsured companies			0	0
13.3 Other amounts receivable under reinsurance contracts			0	0
14. Amounts receivable relating to uninsured plans			0	0
15.1 Current federal and foreign income tax recoverable and interest thereon			0	0
15.2 Net deferred tax asset			0	0
16. Guaranty funds receivable or on deposit			0	0
17. Electronic data processing equipment and software	1,393,955	1,332,099	61,856	367,512
18. Furniture and equipment, including health care delivery assets ($ 964,150)	2,042,213	485,128	1,557,085	3,205,016
19. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
20. Receivables from parent, subsidiaries and affiliates	9,913	9,913	0	0
21. Health care ($ 5,915,750) and other amounts receivable	5,950,558	3,648,805	2,301,753	3,564,657
22. Other assets nonadmitted			0	0
23. Aggregate write-ins for other than invested assets	484,921	484,921	0	0
24. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 10 to 23)	84,632,368	5,961,020	78,671,368	74,024,700
25. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
26. Total (Lines 24 and 25)	84,632,368	5,961,020	78,671,368	74,024,700
DETAILS OF WRITE-INS				
0901.				
0902.				
0903.				
0998. Summary of remaining write-ins for Line 9 from overflow page	0	0	0	0
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9 above)	0	0	0	0
2301. Employee advances	0	0	0	0
2302. Prepaid expenses	484,921	484,921	0	0
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398) (Line 23 above)	484,921	484,921	0	0

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less $ ____ reinsurance ceded)	27,866,108		27,866,108	45,841,077
2. Accrued medical incentive pool and bonus amounts	4,564,279		4,564,279	3,550,379
3. Unpaid claims adjustment expenses	315,924		315,924	676,395
4. Aggregate health policy reserves			0	225,000
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserves			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance			0	220,574
9. General expenses due or accrued	6,708,909		6,708,909	10,338,710
10.1 Current federal and foreign income tax payable and interest thereon (including $ ____ on realized capital gains (losses))			0	0
10.2 Net deferred tax liability			0	0
11. Ceded reinsurance premiums payable			0	0
12. Amounts withheld or retained for the account of others	902,577		902,577	1,093,051
13. Remittance and items not allocated			0	0
14. Borrowed money (including $ ____ current) and interest thereon $ ____ (including $ ____ current)			0	0
15. Amounts due to parent, subsidiaries and affiliates	1		1	1
16. Payable for securities			0	0
17. Funds held under reinsurance treaties with ($. ____ authorized reinsurers and $ ____ unauthorized reinsurers)			0	0
18. Reinsurance in unauthorized companies			0	0
19. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
20. Liability for amounts held under uninsured accident and health plans			0	0
21. Aggregate write-ins for other liabilities (including $ ____ current)	0	0	0	3,473,311
22 Total liabilities (Lines 1 to 21)	40,347,796	0	40,347,796	65,418,528
23. Common capital stock	XXX	XXX		0
24 Preferred capital stock	XXX	XXX		0
25. Gross paid in and contributed surplus	XXX	XXX		0
26. Surplus notes	XXX	XXX		0
27. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
28. Unassigned funds (surplus)	XXX	XXX	36,323,570	8,606,172
29. Less treasury stock, at cost: 29.1 ____ shares common (value included in Line 23 $ ____)	XXX	XXX		0
29.2 ____ shares preferred (value included in Line 24 $ ____)	XXX	XXX		0
30. Total capital and surplus (Lines 23 to 28 Less 29)	XXX	XXX	36,323,570	8,606,172
31. Total liabilities, capital and surplus (Lines 22 and 30)	XXX	XXX	76,671,366	74,024,700
DETAILS OF WRITE-INS				
2101. Provider Tax Liability	0		0	3,473,311
2102.				
2103.				
2198. Summary of remaining write-ins for Line 21 from overflow page	0	0	0	0
2199. Totals (Lines 2101 thru 2103 plus 2198) (Line 21 above)	0	0	0	3,473,311
2701.	XXX	XXX		
2702.	XXX	XXX		
2703.	XXX	XXX		
2798. Summary of remaining write-ins for Line 27 from overflow page	XXX	XXX	0	0
2799. Totals (Lines 2701 thru 2703 plus 2798) (Line 27 above)	XXX	XXX	0	0

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies

A. Accounting Practices

The financial statements of The Wellness Plan (TWP) are presented on the basis of accounting practices permitted by the Michigan Office of Financial and Insurance Services (OFIS).

As of January 1, 2003, OFIS has adopted the NAIC's *Accounting Practices and Procedures* as a component of prescribed and permitted practices. OFIS has certain permitted practices that can be used as a phase-in for the accounting practices.

1. Three-year phase-in period for the limitation of admitted electronic data processing equipment and software (SSAP 16)
2. Three-year phase-in period for the amount of nonadmitted furniture and equipment (SSAP 19)

TWP, with the previous permission of OFIS, records their Malpractice Trust Self Insurance Fund and the Stop Loss Self Insurance Trust on Schedule BA. These two items are not specifically addressed in statutory accounting. If these funds were not allowed as admitted assets, the surplus would be decreased by $1,274,094 as December 31, 2004 and by $2,009,040 as of December 31, 2003.

A reconciliation of the Company's net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the State of Michigan is shown below:

		12/31/04	12/31/03
(1)	Net income – Michigan OFIS basis	$ 28,924,576	$ 5,096,000
(2)	State prescribed practices	-0-	-0-
(3)	State permitted practices	-0-	-0-
(4)	Net income – NAIC SAP	$ 28,924,576	$ 5,096,000
(5)	Statutory surplus – Michigan OFIS basis	$ 38,323,570	$ 8,606,172
(6)	State prescribed practices (surplus):		
	BDP Equipment	-0-	215,440
	Furniture and equipment	592,935	1,802,686
(7)	State permitted practices (surplus):	-0-	-0-
(8)	Statutory surplus – NAIC SAP	$ 37,730,635	$ 6,588,046

B. Use of Estimates in the Preparation of the Financial Statements:

The preparation of financial statements in conformity with NAIC's and OFIS's accounting practices and permitted practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosures of contingent assets and liabilities as of the date of the statement of admitted assets, liabilities and capital and surplus—statutory basis and revenues and expenses and capital and surplus—statutory basis for the period reported on. Actual results could differ from those estimates.

C. Accounting Policy:

Fair Value of Financial Instruments—The carrying amounts of cash, short-term investments, receivables, accounts payable, and accrued expenses approximate fair value due to the short maturity of these items. Investments are valued at fair values, which are based on quoted market prices.

Cash and Short-Term Investments—Cash and short-term investments are carried at cost, which approximate fair market value, and are comprised of cash and highly liquid short-term investments with an original maturity of 90 days or less.

Investments—Investments consist primarily of mutual funds and short-term interest bearing investments with original maturities greater than three months. Investments are stated at fair value, which are based on quoted market prices. Investment income, including interest, dividends and realized gains and losses are included in the statement of revenue over expenses. Unrealized gains and losses are excluded from excess of expenses over revenues.

Inventories—Inventories are stated at the lower of cost or market, determined by the first-in, first-out method.

Property and Equipment—Property and equipment are stated at cost. Depreciation is

NOTES TO FINANCIAL STATEMENTS

computed by the straight-line method over the estimated useful lives of the respective assets, which range from 3 to 30 years.

Statutory Reserves—As a condition of licensure with the State of Michigan, the Corporation is required to maintain in a contingency fund a deposit of $1,000,000 as of December 31, 2004 and 2003, as an additional resource to provide for health care services for its members. This deposit is restricted and is held in a jointly administered trust fund with the Michigan Insurance Bureau. The funds are invested in certificates of deposit and U.S. Government securities and recorded as cash and short-term investments.

Revenue Recognition—Revenue is recognized during the month in which coverage for enrolled members is in effect. Unearned revenue represents advance billings prior to that in which coverage is in effect.

Accrued Medical Claims—Health care costs are accrued in the period services are provided to the enrolled members based in part on estimates, including an accrual for medical services provided but not yet reported. Such estimates are based on historical payment patterns using actuarial techniques and are regularly reviewed and updated. Differences in estimates resulting there from are reflected in current operations.

Malpractice Costs—The provision for estimated medical malpractice claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Income Tax Status—The Corporation is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code; accordingly, no provision for federal income taxes has been made in the financial statements.

2. Accounting Changes and Correction of Errors

As of January 1, 2003, OFIS has adopted the NAIC's Accounting Practices and Procedures as a component of prescribed and permitted practices. OFIS has certain prescribed practices that can be used as a phase-in for the accounting procedures.

• The Company's Retired Employees Health Insurance Fund was redetermined during 2004. Any funding exceeding the actuarially determined liabilities was transferred to the Company operations, and is no longer required to be reported as a nonadmitted asset. The amount reported as a nonadmitted asset as of December 31, 2003 is based on the following amounts:

	12/31/04	12/31/03
Employee Benefit Trust Fund – Investments	644,613	659,080
Employee Benefit Trust Fund – Cash	-0-	1,194,668
Subtotal	644,613	1,853,748
Accrued Pension Benefit Liability	644,613	823,963
Prepaid employee benefits	-0-	1,029,785

• The reported amount for computer hardware is limited to 15%, for 2004, and 25%, for 2003, of the Company's capital surplus, as allowed under the State of Michigan prescribed accounting practices. The amount of the Company's non-operating systems software is treated as a non-admitted asset.

	12/31/04	12/31/03
Capital and surplus, beginning of period	21,612,564	5,069,062
Percentage allowed	15%	25
Allowable limit of computer equipment	3,241,885	1,267,266
Amount of EDP equipment and software	1,393,965	2,477,122
Less amount of EDP software	1,332,099	2,109,610
Net amount of EDP equipment	61,866	367,512
Admitted amount (not to exceed the allowable limit as determined above)	61,866	367,512
Nonadmitted amount	1,332,099	2,109,610

• Office Furniture and Equipment is stated at 55%, for 2004, and 85%, for 2003, of the net book value as allowed under the State of Michigan's prescribed accounting practices.

NOTES TO FINANCIAL STATEMENTS

	12/31/04	12/31/03
Furniture and Equipment	$ 2,042,213	$ 3,523,137
Less: Medical Delivery assets **	964,150	1,402,330
Net Office Equipment	1,078,063	2,120,807
Admitted amount at 55% of total (2004)	592,935	
Admitted amount at 85% of total (2003)		1,802,686
Nonadmitted amount	485,128	318,121

** Medical Delivery assets of $964,150 and $1,402,330 at December 31, 2004 and December 31, 2003, respectively, consists of inventory of medical supplies, drugs and staff clinics equipment and were deducted from the total office furniture and equipment when determining the amount of nonadmitted assets.

• The estimated useful lives of the Company's computer hardware, software, and medical equipment were recently re-evaluated to comply with SSAP Statements 16, 19, and 73, which resulted in an one-time charge to depreciation expense that was recorded as of June 30, 2004. The one-time charge, which was recorded in June 2004, totalled about $320,000.

• During 2003, the Corporation recognized an impairment loss resulting from the adjustment to fair market value for the land and building at Northwest Health Center.

Original cost of property	$ 9,013,215
Less: accumulated depreciation	2,997,839
Net book value before impairment loss	6,015,376
Less fair market value per appraisal	5,000,000
Impairment loss recognized in 2003	$ 1,015,376

• Prior period adjustments as shown as an aggregate write-in on the Capital and Surplus schedule (see page 5), were included in the Audited Financial Statements for the year ended December 31, 2002, and represent the adjustment of claims incurred but not reported totalling $6,312,308.

3. Business Combinations and Goodwill:

   A. Statutory Purpose Method: Not applicable
   B. Statutory Merger: Not applicable
   C. Assumption Reinsurance: Not applicable
   D. Impairment Loss: Not applicable

4. Discontinued Operations:

   The Michigan Department of Community Health did not renew its contract for Medicaid coverage, which expired September 30, 2004. As a result, all remaining members were sold either to Molina Healthcare of Michigan (membership in Wayne, Oakland, Muskegon and Oceana Counties), McLaren Health Plan (membership in Genesee and Lapeer Counties) or to Total Health Care (membership in Macomb County). The total sale price amounted to $22,698,253 and is reported on the Statement of Revenue and Expenses (Page 4) on Line 29 and is included in the Cash Flow (Page 6) in Line 16.6.

   The Company ended its commercial line of business for practically all of its groups on June 30, 2004 or earlier, as well as the contract for the Company's employee health care coverage, which ended July 31, 2004.

5. Investments (Mortgage Loans, Debt Restructuring, Reverse Mortgages, Loan-Backed Securities and Repurchase Agreements)

   A. Mortgage Loans: Not applicable
   B. Debt Restructuring: Not applicable
   C. Reverse Mortgages: Not applicable
   D. Loan-Backed Securities: Not applicable
   E. Repurchase Agreements: Not applicable
   F. Real Estate: Not applicable

6. Joint Ventures, Partnerships and Limited Liability Companies: Not applicable

7. Investment Income: Not applicable

8. Derivative Instruments: Not applicable

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes:

The corporation is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for federal income taxes has been made.

10. Information Concerning Parent, Subsidiaries and Affiliates:

Wellcorp, Inc.: the reported value of this subsidiary is $9,913 at December 31, 2004 and is treated as a non-admitted asset for statutory reporting purposes.

WellChoice: The reported value of this subsidiary is $-0- at December 31, 2004.

11. Debt: None

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan: Not applicable
B. Defined Contribution Plans: Corporation employees are covered by a qualified defined contribution pension plan sponsored by The Wellness Plan. Contributions of six percent (6%) of each employee's compensation are made each year. The corporation's contribution to the plan was $882,288 for 2004 and $948,200 for 2003. At December 31, 2004, the fair value of plan assets was $10,533,849.
C. Multiemployer Plans: Not applicable
D. Consolidated/Holding Company Plans: Not applicable
E. Postemployment Benefits and Compensated Absences: The Employees' Retirement Health Care Plan replaces the defined benefit postretirement health care plan, which was terminated in July 2001, and covers 17 retired employees who were receiving benefits under the old plan. Plan assets totaled $644,613 at December 31, 2004 and $1,853,873 at December 31, 2003 and consist of equity and bond mutual funds and cash equivalents.

13. Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

Not applicable

14. Contingencies:

Litigation: Various lawsuits are filed against the Corporation for incidents which arise in the ordinary course of business. In the opinion of the Corporation's management, the outcome of the lawsuits will not have a material adverse effect on the financial position of the Corporation.

Malpractice Self-Insurance: The Corporation purchased insurance policies to provide for medical malpractice claims up to a maximum of $200,000. In conjunction with this insurance policy, the Corporation also has a self-insurance program in effect which provides for claims exceeding $200,000.

WellChoice: The Texas Department of Insurance placed the Corporation's subsidiary, WellChoice, into temporary receivership in February 1999. In June 2000, the Texas Department of Insurance filed a claim against the Corporation to recover the outstanding liabilities of WellChoice. Management believes that any obligation the Corporation may incur on behalf of WellChoice would not have a material adverse effect on the consolidated financial position of the Corporation.

15. Leases:

The following is a schedule of future minimum rental payments required under operating leases that have initial or remaining noncancelable lease terms in excess of one year at December 31, 2004.

2005	$ 225,929
2006	130,345
2007	108,723
2008	41,964
Total minimum payments required:	$ 206,961

NOTES TO FINANCIAL STATEMENTS

The total rental expense for all operating leases amounted to $357,293 in 2004 and $557,419 in 2003.

16. Information about Financial Instruments With Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk:

Not applicable

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales: Not applicable
B. Transfer and Servicing of Financial Assets: Not applicable
C. Wash Sales: Not applicable

18. Gain or Loss to the Reporting Entity from Uninsured A&H Plans and the Uninsured Portion of Partially Insured Plans

A. ASO Plans: Not applicable
B. ASC Plans: Not applicable
C. Medicare or Similarly Structured Cost Based Reimbursement Contract: Not applicable

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

Not applicable

20. September 11 Events: Not applicable

21. Other Items: Not applicable

A. Extraordinary Items: Not applicable
B. Troubled Debt Restructuring: Debtors: Not applicable
C. Other Disclosures: Not applicable
D. Uncollectible assets covered by SSAP 6: No changes
E. Business Interruption Insurance Recoveries: Not applicable

22. Events Subsequent:

None after December 31, 2004. Items reported in this section earlier in the year were transferred to the discontinued operations section. (See Note #4.)

23. Reinsurance:

A. Ceded Reinsurance Report: Not applicable
B. Uncollectible Reinsurance: Not applicable
C. Commutation of Ceded Reinsurance: Not applicable

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination: Not applicable

25. Change in Incurred Claims and Claim Adjustment Expenses

Reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased $8,163,969 from $49,391,456 at December 31, 2003 to $41,227,487 at December 31, 2004 as a result of the reestimation of unpaid claims and claim adjustment expenses. This decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased when additional information becomes known regarding individual claims.

On July 1, 2003, the Corporation was placed under an Order of Rehabilitation. Unpaid claims for services provided to the Rehabililitation Order include the following amounts:

NOTES TO FINANCIAL STATEMENTS

Medical claims	$ 20,208,959
Other medical liabilities	1,550,472
IPA cost settlements	3,048,897
Retention withholds	214,304
Accounts payable	1,401,941
Total	$ 26,424,573

26. Intercompany Pooling Arrangements: Not applicable

27. Structured Settlements: Not applicable

28. Health Care Receivables:

A. Pharmaceutical Rebate Receivables:

	Estimated pharmacy rebates as reported on financial statements	Pharmacy rebates as billed or otherwise confirmed	Actual rebates received within 90 days of billing	Actual rebates received within 91 - 180 days of billing	Actual rebates received more than 180 days after billing
12/31/2004	255,505	45,427	-0-	-0-	5,495
9/30/2004	215,573	50,782	-0-	-0-	126,221
6/30/2004	291,012	-0-	-0-	-0-	322,542
3/31/2004	613,553	(146,420)	-0-	-0-	254,611
12/31/2003	1,014,585	729,733	-0-	-0-	601,972
9/30/2003	886,824	336,039	-0-	-0-	208,089
6/30/2003	758,874	79,807	-0-	-0-	147,582
3/31/2003	826,649	237,408	-0-	-0-	237,854
12/31/2002	827,095	342,202	-0-	-0-	235,107
9/30/2002	720,000	380,727	-0-	-0-	487,610
6/30/2002	826,883	245,991	-0-	-0-	304,256
3/31/2002	885,148	240,229	-0-	-0-	335,103

B. Risk Sharing Receivables:

Calendar year	Evaluation period ending year	Risk sharing receivable as estimated in the prior year	Risk sharing receivable as estimated in the current year	Risk sharing receivable billed	Risk sharing receivable not yet billed	Actual risk sharing amounts received in year billed	Actual risk sharing amounts received in second subsequent year	Actual risk sharing amounts received - all other
2004	2004	335,349	335,877	-0-	355,877	-0-		
	2005		-0-					
2003	2003	717,782	658,733	717,782		-0-		
	2004		335,349					
2002	2002	45,334	332,844	45,334	287,510	-0-	58,725	19,575
	2003		717,782					

29. Participating Policies: Not applicable

30. Premium Deficiency Reserves

At December 31, 2003, the Company recorded a loss of $225,000 in commercial premium deficiency reserves based on expected losses occurring during 2004. Resulting from the net reduction of commercial membership as well as the reduction in incurred claims expenses, $225,000 was recognized as a reduction of medical expenses for the year ended December 31, 2004.

31. Anticipated Salvage and Subrogation: Not applicable

STATE OF MICHIGAN
IN THE INGHAM COUNTY CIRCUIT COURT

LINDA A. WATTERS, COMMISSIONER,
OFFICE OF FINANCIAL AND INSURANCE SERVICES
FOR THE STATE OF MICHIGAN,

Petitioner,

File No. 03-1127-CR

v.

THE WELLNESS PLAN,
A Michigan health maintenance organization

Hon. William E. Collette

Respondent.

/

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PROOF OF SERVICE

The undersigned certifies that a copy of the *Brief on the Issue of Priority of Provider Claims Submitted by Harry L. Sivley, Special Deputy Receiver of Comprehensive Health Services of Texas, d/b/a Wellchoice* and this *Proof of Service* were served upon counsel for Plaintiff at his business address as disclosed on the pleadings on April 20, 2005, via first-class U. S. Mail, from Lansing, Michigan. I declare under penalty of perjury that this is true to the best of my knowledge, information and belief.

CAROLYN R. LINDEMAN

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